

Federal Employees
Health Benefits Program

Health Benefits Election Form

Part A - Enrollee and Family Member Information *(For additional family members use a separate sheet and attach.)*

1. Enrollee name <i>(last, first, middle initial)</i>	2. Social Security number	3. Date of birth <i>(mm/dd/yyyy)</i>	4. Sex <input type="checkbox"/> M <input type="checkbox"/> F	5. Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Home mailing address <i>(including ZIP Code)</i>		7. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		8. Medicare Claim Number
10. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: <i>Name of other insurance:</i> _____ <i>Policy number:</i> _____		9. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 10 below. <input type="checkbox"/> No		
<input type="checkbox"/> FEHB <i>An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.</i>				

11. Name of family member <i>(last, first, middle initial)</i>	12. Social Security number	13. Date of birth <i>(mm/dd/yyyy)</i>	14. Sex <input type="checkbox"/> M <input type="checkbox"/> F	15. Relationship code
16. Address <i>(if different from enrollee)</i>		17. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		18. Medicare Claim Number
20. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: <i>Name of other insurance:</i> _____ <i>Policy number:</i> _____		19. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 20 below. <input type="checkbox"/> No		
<input type="checkbox"/> FEHB <i>An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.</i>				

21. Email address <i>(if home address is different from enrollee's)</i>	22. Preferred telephone number <i>(if home address is different from enrollee's)</i>
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23. Name of family member <i>(last, first, middle initial)</i>	24. Social Security number	25. Date of birth <i>(mm/dd/yyyy)</i>	26. Sex <input type="checkbox"/> M <input type="checkbox"/> F	27. Relationship code
28. Address <i>(if different from enrollee)</i>		29. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		30. Medicare Claim Number
32. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: <i>Name of other insurance:</i> _____ <i>Policy number:</i> _____		31. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 32 below. <input type="checkbox"/> No		
<input type="checkbox"/> FEHB <i>An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.</i>				

33. Email address <i>(if home address is different from enrollee's)</i>	34. Preferred telephone number <i>(if home address is different from enrollee's)</i>
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35. Name of family member <i>(last, first, middle initial)</i>	36. Social Security number	37. Date of birth <i>(mm/dd/yyyy)</i>	38. Sex <input type="checkbox"/> M <input type="checkbox"/> F	39. Relationship code
40. Address <i>(if different from enrollee)</i>		41. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		42. Medicare Claim Number
44. Indicate the type(s) of other insurance: <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: <i>Name of other insurance:</i> _____ <i>Policy number:</i> _____		43. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 44 below. <input type="checkbox"/> No		
<input type="checkbox"/> FEHB <i>An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.</i>				

45. Email address <i>(if home address is different from enrollee's)</i>	46. Preferred telephone number <i>(if home address is different from enrollee's)</i>
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Part B - FEHB Plan You Are Currently Enrolled In <i>(if applicable)</i>		Part C - FEHB Plan You Are Enrolling In or Changing To	
1. Plan name	2. Enrollment code	1. Plan name	2. Enrollment code
Part D - Event That Permits You To Enroll, Change, or Cancel <i>(see page 2)</i>		Part E - Election NOT to Enroll <i>(Employees Only)</i>	
1. Event code	2. Date of event	<input type="checkbox"/> I do NOT want to enroll in the FEHB Program. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.</i>	
Part F - Cancellation of FEHB		Part G - Suspension of FEHB <i>(Annuitants/Former Spouses Only)</i>	
<input type="checkbox"/> I CANCEL my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.</i>		<input type="checkbox"/> I SUSPEND my enrollment. <i>My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.</i>	
Part H - Signature			
WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)			
1. Your signature <i>(do not print)</i>		2. Date <i>(mm/dd/yyyy)</i>	
3. Email address		4. Preferred telephone number	
Part I -To be completed by agency or retirement system			
REMARKS			
1. Date received <i>(mm/dd/yyyy)</i>	2. Effective date of action <i>(mm/dd/yyyy)</i>	3. Personnel telephone number	
4. Name and address of agency or retirement system		5. Authorizing official <i>(please print)</i>	
		6. Signature of authorized agency official	
7. Payroll office number	8. Payroll office contact <i>(please print)</i>	9. Payroll telephone number	